F. In the event of liquidation of a fund, the commissioner shall levy an assessment upon its members for such amounts as the commissioner determines to be necessary to discharge all liabilities of the fund, including the reasonable costs of liquidation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1129. Review of Rate Determination

A. Funds shall provide reasonable means whereby any member aggrieved by the application of the fund's rating system may, in writing, request a review of the manner in which such rating system has been applied in connection with the coverage afforded. The fund shall have 30 days from receipt to grant or deny the request, in writing. If the fund rejects such request or fails to grant or reject such request within such 30-day period, the member may, within 30 days following the expiration of such 30-day period, appeal to the commissioner, who, after a hearing held upon not less than 10 days' written notice to the member and to the fund, may affirm or reverse such action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1131. Cease and Desist Orders

A. After notice and opportunity for a hearing, the commissioner may issue an order requiring a person or group to cease and desist from engaging in an act or practice found to be in violation of any provision of this regulation.

B. Upon finding, after notice and opportunity for a hearing, that any person or group has violated any cease and desist order, the commissioner may revoke the group's certificate of authority.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1133. Revocation of Certificate of Authority

A. After notice and opportunity for a hearing, the commissioner may revoke a group's certificate of authority if:

1. the group is found to be insolvent;

2. the group fails to pay any premium tax, regulatory fee, or assessment, or special fund contribution imposed upon it;

3. the group fails to comply with any of the provisions of this regulation, or with any lawful order of the commissioner within the time prescribed;

4. the certificate of authority issued to the group was obtained by fraud;

5. there was a material misrepresentation in the application for the certificate of authority, or

6. the group or its administrator has misappropriated, converted, illegally withheld, or refused to pay over upon proper demand any monies held in a fiduciary capacity that belong to a member, an employee of a member, or another person.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1135. Examinations

A. The commissioner may examine the affairs, transactions, accounts, records, assets, and liabilities of a fund as often as the commissioner deems advisable. The expenses of such examinations shall be paid by the fund being examined.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

Chapter 13. Regulation 43C Companies in Hazardous Financial Condition

§1301. Purpose

A. The purpose of this regulation is to set forth the standards which the Commissioner of Insurance (the "commissioner") may use for identifying insurers found to be in such condition as to render the continuance of their business hazardous to the public or to holders of their policies or certificates of insurance.

B. This regulation shall not be interpreted to limit the powers granted the commissioner by any laws or parts of laws of the state of Louisiana, nor shall this regulation be interpreted to supersede any laws or parts of laws of the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2(H).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1408 (December 1992).

§1303. Definitions

A. As used in this regulation, the following terms shall have the respective meaning hereinafter set forth:

Control as defined in R.S. 22:1002(3).

Person as defined in R.S. 22:1002(7).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2(H).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1408 (December 1992).

§1305. Standards

A. The following standards, either singly or a combination of two or more, may be considered by the commissioner to determine whether the continued operation of any insurer transacting an insurance business in this state might be deemed to be hazardous to the policyholders, creditors, or the general public. The commissioner may consider:

1. adverse findings reported in financial condition and market conduct examination reports or reported in required financial reports;

2. the National Association of Insurance Commissioners Insurance Regulatory Information System, its related reports and caveats;

3. the ratios of commission expense, general insurance expense, policy benefits, and reserve increases as to annual premium and net investment income which could lead to an impairment of capital and surplus;

4. the insurer's asset portfolio when viewed in light of current economic conditions is not of sufficient value, liquidity, or diversity to assure the company's ability to meet its outstanding obligations as they mature;

5. the ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the company's remaining surplus after taking into account the insurer's cash flow and the classes of business written, as well as the financial condition of the assuming reinsurer;

6. the insurer's operating loss in the last 12-month period or any shorter period of time including, but not limited to, net capital gain or loss, change in non-admitted assets, and cash dividends paid to shareholders, is greater than 50 percent of such insurer's remaining surplus as regards policyholders in excess of the minimum required;

7. whether any affiliate, subsidiary or reinsurer is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligations;

8. contingent liabilities, pledges, or guarantees which either individually or collectively involve a total amount which, in the opinion of the commissioner, may affect the solvency of the insurer;

9. whether any person having control of an insurer is delinquent in the transmitting to, or payment of, net premiums to such insurer;

10. the age and collectibility of receivables;

11. whether the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of such insurer, fails to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurer in such position;

12. whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false and misleading information concerning an inquiry;

13. whether management of an insurer either has filed any false or misleading sworn financial statement, or has released any false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer;

14. whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner; or

15. whether the insurer has experienced or will experience in the foreseeable future cash flow and/or liquidity problems.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2(H).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1408 (December 1992).

§1307. Commissioner's Authority

A. For the purposes of making a determination of an insurer's financial condition under this regulation, the commissioner may:

1. disregard any credit or amount receivable resulting from transactions with a reinsurer which is insolvent, impaired, or otherwise subject to a delinquency proceeding;

2. make appropriate adjustments to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates;

3. refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; or

4. increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise disclosed if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next 12-month period.

B. If the commissioner determines that the continued operation of the insurer licensed to transact business in this state may be hazardous to the policyholders or the general public, then the commissioner may, upon his determination, issue an order requiring the insurer to:

1. reduce the total amount of present and potential liability for policy benefits by reinsurance;

2. reduce, suspend, or limit the volume of business being accepted or renewed;

3. reduce general insurance and commission expenses by specified methods;

4. increase the insurer's capital and surplus;

5. suspend or limit the declaration and payment of dividends by an insurer to its stockholders or to its policyholders;

6. file reports in a form acceptable to the commissioner concerning the market value of an insurer's assets;

7. limit or withdraw from certain investments or discontinue certain investment practices to the extent the commissioner deems necessary;

8. document the adequacy of premium rates in relation to the risks insured; or

9. file, in addition to regular annual statements, interim financial reports on the form adopted by the National Association of Insurance Commissioners or on such format as promulgated by the commissioner.

10. If the insurer is a foreign insurer, the commissioner's order may be limited to the extent provided by statute.

C. Within 30 days of receipt of notification of the order of the commissioner to the insurer made pursuant to §1307.B, the insurer may make written demand for a hearing pursuant to the provisions of Part XXIX of Chapter I of Title 22 of the Louisiana Revised Statutes of 1950; provided, however, that such a hearing will be held privately, unless the insurer requests a public hearing, in which case the hearing shall be public.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2(H).
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1408 (December 1992).

Chapter 15. Regulation 44C Accelerated Benefits

§1501. Purpose

A. The purpose of this regulation is to regulate accelerated benefit provisions of individual and group life insurance policies and to provide required standards of disclosure. This regulation shall apply to all accelerated benefits provisions of individual and group life insurance policies except those subject to the Long-Term Care Insurance Model Act, issued or delivered in this state, on or after the effective date of this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

§1503. Definitions

Accelerated Benefits covered under this regulation benefits payable under a life insurance contract:

1. to a policy owner or certificate holder, during the lifetime of the insured, in anticipation of death or upon the occurrence of specified life-threatening or catastrophic conditions, as defined by the policy or rider; and

2. which reduce the death benefit otherwise payable under the life insurance contract; and

3. which are payable upon the occurrence of a single qualifying event which results in the payment of a benefit amount fixed at the time of acceleration.

Qualifying Event includes one or more of the following:

1. a medical condition which would result in a drastically limited life span as specified in the contract, for example, 24 months or less; or

2. a medical condition which has required or requires extraordinary medical intervention, such as, but not limited to, major organ transplant or continuous artificial life support, without which the insured would die; or

3. any condition which usually requires continuous confinement in an eligible institution, as defined in the contract, if the insured is expected to remain there for the rest of his or her life; or

4. a medical condition which would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, *but are not limited to*, one or more of he following:

a. coronary artery disease resulting in an acute infarction or requiring surgery;

b. permanent neurological deficit resulting from cerebral vascular accident;

c. end stage renal failure;

d. Acquired Immune Deficiency Syndrome; or

e. other medical conditions which the commissioner shall approve for any particular filing; or

5. other qualifying events which the commissioner shall approve for any particular filing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

§1505. Type of Product

A. Accelerated benefit riders and life insurance policies with accelerated benefit provisions are primarily mortality risks rather than morbidity risks. They are life insurance benefits subject to R.S. 22:161-181; 22:191-197; and the applicable portions of Part XIV, (22:611-672).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

§1507. Assignee/Beneficiary

A. Prior to the payment of the accelerated benefit, the insurer is required to obtain from any assignee or irrevocable beneficiary a signed acknowledgment of concurrence for payout. If the insurer making the accelerated benefit is itself the assignee under the policy, no such acknowledgment is required.